

KANSAS MEDICAID	
PRIOR AUTHORIZATION	Į
Selzentry ® (Maraviroc)	

0.4507	,	Request Date	
31507			
Beneficiary Medicaid ID Number	BENEFICIARY INFORMATION	Beneficiary Date of Birth	
Selfericiary Medicald ID Number		Deficiency Date of Birth	
Beneficiary Full Name			
Prescriber's Full Name	PRESCRIBER INFORMATION		
Prescriber Street Address		 	
City	State	Zip Code	
Prescriber Phone:	Prescr	iber Fax:	
Prescriber Medicaid ID #		Prescriber NPI #	
UDC Democrade	<u> </u>		
NDC Requested:			
StrengthQuantity	Length of Therapy		
Prescription instructions(sig):			
1. Is the prescriber an HIV Special	list? YesNo		
2. Was the patient previously enrolled in the Pfizer Expanded Access Program? YesNo			
3. Is the patient infected with CXCR4-tropic HIV-1 (dual/mixed tropic)? YesNo			
4. Is the patient infected with CCR5-tropic HIV-1 (R5 HIV-1) detectable and also has viral replication and			
HIV-1 strains resistant to multip	ole antiretroviral agents? Yes	No	
O'materia of Bases "			
Signature of Prescriber	*Proceribor cignature mandatory	L ′ L ′ L ′ L Date	



FAX TO: KANSAS Medicaid Prior Authorizations Fax: (866) 246-8512 PA HELPDESK: (877) 475 - 7567

